Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be additional reimbursement of $18,136.50 for dates of service 06/25/01 through 08/14/01.

   b. The request was received on 05/29/02.

II. EXHIBITS

1. Requestor, Exhibit I:

   a. TWCC 60 and Letter Requesting Dispute Resolution
   b. HCFA(s)
   c. TWCC 62 forms
   d. EOBs from other carriers
   e. Medical Records
   f. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

2. Respondent, Exhibit II:

   a. TWCC 60
   b. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

3. Per Rule 133.307 (g) (3), the Division forwarded a copy of the requestor's 14 day response to the insurance carrier on 07/02/02. Per Rule 133.307 (g) (4), the carrier representative signed for the copy on 008/02. The response from the insurance carrier was received in the Division on 07/13/02. Based on 133.307 (i) the insurance carrier's response is timely.

4. A letter Requesting Additional Information is reflected as Exhibit III of the Commission's case file.

III. PARTIES' POSITIONS

1. Requestor: Letter dated 05/23/02.
   "A sample of EOBs also has been included from the major carriers. (Provider) invites the (Carrier) (or TWCC) to verify this information in any manner necessary to satisfy any

doubts that might exist about the accuracy and legitimacy of the information presented. The EOBs are identified by a letter, which corresponds to a code letter included on the 'Reimbursements of Pain Management.' This should facilitate verification of the information presented while still protecting patient confidentiality. Also enclosed is a summary of the average reimbursements paid (by percentage of charges and by the hour) by 21 of the major carriers in Texas for non-CARF accredited pain programs, and an entry which averages the reimbursements paid by 50 of the other carriers included in (Providers) full survey."

2. Respondent: No response found in the dispute packet.

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only dates of service eligible for review are those commencing on 06/25/01 through 08/14/01.

2. The explanation of denial listed on the EOBs is, "M-THE REIMBURSEMENT FOR THE SERVICE RENDERED HAS BEEN DETERMINED TO BE FAIR AND REASONABLE BASED ON BILLING AND PAYMENT RESEARCH AND IS IN ACCORDANCE WITH LABOR CODE 413.011(B); F-REDUCED IN ACCORDANCE WITH THE APPROPRIATE TWCC FEE GUIDELINE'S MAXIMUM ALLOWABLE REIMBURSEMENT (MAR)."

3. The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT or Revenue CODE	BILLED	PAID	EOB Denial Code(s)	MAR$	REFERENCE	RATIONALE:
06/25/01	97799-CP for all dates of service	$1,162.50 (7.75 units)	$573.50	M	DOP	TWCC Act & Rules Sec. 413.011 (d), Rules 133.304 (i) & 133.307 (G)(3)(D) MFG;MGR (II)(C)(G), (II)(G)(8)	The provider has included in their dispute packet, documentation (EOBs from other carriers) that provides some evidence of "fair and reasonable" reimbursement per Sec. 413.011(d). The provider is a non-CARF accredited facility, therefore billed amount will be reduced 20% according to the Fee Guidelines. The carrier did not respond to this dispute. The provider billed in accordance with the referenced Rule and medical documentation indicates that the services were rendered. The carrier as required by Rule 133.304(i) submitted no evidence of a methodology. The provider billed an hourly rate of $150.00 for the services rendered. The carrier reimbursed the provider an average of $72.00 an hour for the dates of service. The provider has submitted reimbursement data, from other carriers, that indicates they have been willing to accept $100.00 an hour, for CPT code 97799-CP. This is the fee after the 20% reduction, due to non-CARF accreditation. ($125 x .20 = $100) The Medical Review Division must review the evidence submitted to determine which party has provided the most persuasive evidence to support fair and reasonable since there is no MAR. The carrier has failed to submit a response or a methodology. The provider has submitted some evidence of fair and reasonable. For the dates of service that exceed the 8 hour maximum, these hour increments will be deducted form the total billed. DOS 06/26/01-.25, 06/27/01-.25, 07/09/01-.25, 07/10/01-.25, 07/11/01-.25, 07/12/01-.25, 07/13/01-.25, 07/24/01-.25, 07/25/01-.25, and 07/31/01-.50, for a total of **2.75** hours to be subtracted from the total bill. Based on the evidence of fair and reasonable, the provider indicates $100.00 is an acceptable rate. Therefore, reimbursement is recommended in the amount of **$6,311.50.** ($100.00 x 236.50 – 2.75 = 233.50 hours billed = $23,350.00-$17,038.50 already paid = $6,311.50).
06/26/01		$1,237.50 (8.25 units)	$592.00	M			
06/27/01		$1,237.50 (8.25 units)	$592.00	M			
06/28/01		$1,125.00 (7.5 units)	$555.00	M			
06/29/01		$1,162.50 (7.75 units)	$573.50	M			
07/02/01		$862.50 (5.75 units)	$425.50	M			
07/03/01		$75.00 (.5 units)	$0.00	M			
07/05/01		$1,162.50 (7.75 units)	$573.50	M			
07/06/01		$1,200.00 (8.0 units)	$444.00	M			
07/09/01		$1,237.50 (8.25 units)	$592.00	M			
07/10/01		$1,237.50 (8.25 units)	$592.00	M			
07/11/01		$1,237.50 (8.25 units)	$592.00	M			
07/12/01		$1,237.50 (8.25 units)	$592.00	M			
07/13/01		$1,237.50 (8.25 units)	$592.00	M			
07/16/01		$1,162.50 (7.75 units)	$573.50	M			
07/17/01		$1,125.00 (7.5 units)	$555.00	M			
07/19/01		$1,200.00 (8.0 units)	$592.0	M			
07/20/01		$1,200.00 (8.0 units)	$592.00	M			
07/23/01		$1,200.00 (8.0 units)	$592.00	M			
07/24/01		$1,237.50 (8.25 units)	$610.50	M			
07/25/01		$1,237.50 (8.25 units)	$610.50	M			
07/26/01		$1,125.00 (7.5 units)	$555.00	M			
07/27/01		$1,162.50 (7.75 units)	$573.50	M			
07/30/01		$1,162.50 (7.75 units)	$573.50	M			
07/31/01		$1,275.00 (8.5 units)	$592.00	M			
08/01/01		$1,162.50 (7.75 units)	$573.50	M			
08/06/01		$937.50 (6.25 units)	$462.50	M			
08/07/01		$75.00 (.5 units)	$0.00	M			
08/08/01		$1,162.50 (7.75 units)	$573.50	M			
08/09/01		$1,162.50 (7.75 units)	$573.50	M			
08/10/01		$1,162.50 (7.75 units)	$573.50	M			
08/13/01		$1,162.50 (7.75 units)	$573.50	M			
08/14/01		$75.00 (.5 units)	$0.00	M			
Totals		$35,400.00	$17,038.50				The Requestor **is** entitled to reimbursement in the amount of **$6,311.50.**

The above Findings and Decision are hereby issued this 3rd day of March, 2003.

Michael Bucklin
Medical Dispute Resolution Officer
Medical Review Division

MB/mb

V. ORDER

Pursuant to Sections 402.042, 413.016, 413.031, and 413.019 the Medical Review Division hereby ORDERS the Respondent to remit $6,311.50 plus all accrued interest due at the time of payment to the Requestor within 20 days receipt of this order.

This Order is hereby issued this 3rd day of March 2003.

Carolyn Ollar
Supervisor Medical Dispute Resolution
Medical Review Division

CO/mb